EXHIBIT 7

File No. 84054

Guardian

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
Main Only: Claims Service and Solutions Group
PO Box 981593, El Paso, TX 79998-1593
A wholly owned stock subsidiary of and administrator for
The Guardian Life Insurance Company of America, New York, NY
Toll-Free (888) 275-7473 Fax (413) 395-5984

Psychiatric Physician's Statement | Questions regarding this form? Call Toll Free 1-888-275-7473

Please return completed form via email: diclaims@glic.com, fax: 413-395-5984 or regular mail at the address above

To the Physician: Please provide answers to the questions below to support our evaluation of your patient's claim for disability benefits.

Patient's Name	File No.	Date of Birth
Wairimu Waiyak Patients Chief	84054	

Complaint(s):

Date of First Visit: 03.31.2021 Date of most recent visit: 04.20.2023 Date of Next Visit 05.04.2023

	Diagnosis(es):	ICD-10 / DSM-V Code(s):
1.	Major Depressive Disorder	F32.1
2.	Post-Traumatic Stress Disorder	F43.10
3.		

Do you believe you have a sufficient understanding of this patient's occupation(s) and job duties to comment on their functional ability to work? ☒ Yes ☐ No

If yes, what is your understanding of this patient's occupation(s) and job duties? Client works in Financial Services, completing reports which requires significant mental and physical energy.

Are you advising this patient to:

a) Restrict or limit work activities? ☐ Yes ☒ No If yes, as of what date? ___/___/___
If yes, what aspects of this patient's job duties are they restricted or limited from performing?

b) Stop working altogether? ☒ Yes ☐ No If yes, as of what date? 05 / 01 / 2023
If yes, what aspects of this patient's job duties are they unable to perform?

What is the patient's anticipated time frame for return to work? Six months from approved leave date

Does this patient have a history of a psychiatric condition? ☒ Yes ☐ No

Does this patient have a history of substance abuse? ☐ Yes ☒ No

Specify current treatment plan / type of treatment (i.e., CBT, DBT, EMDR, Medication Management, IOP, Frequency of Visits, etc.):

Client participates in Acceptance Commitment Therapy and DBT.

Current medications (include dosage, frequency and last date of change):

None at this time

Treatment goals:

1. Identify and replace thoughts and beliefs that support depression. 2. verbalize insight into how recent job dynamics may be influencing current experience with depression.

Does the treatment plan include return to work goals? ☒ Yes ☐ No Please explain: One of the objectives is to effectively alleviate depressive symptoms so that client may return to activities of daily living.

Is this patient compliant with your recommended treatment? ☒ Yes ☐ No

Have you discussed your treatment plan and return to work goals with this patient? ☒ Yes ☐ No

Is this patient in agreement with the treatment plan? ☒ Yes ☐ No

Test results or other rating scale score (please specify test, scale, measure used, and date):
PHQ-9 Score 15

Objective observations of this patient's behaviors, affect, mood:
Client presents with flat affect and depressed mood AEB crying spells, slow speech, averted eyes

Subjective complaints reported by this patient (include frequency, severity, duration):
reduced interest in daily activities, loss of appetite, excessive fatigue

Is this patient treating with any other provider(s)? ☐ Yes ☒ No
If yes, please include name and specialty:

Are you coordinating care with this provider(s)? ☐ Yes ☐ No If yes, last date of contact:

How would you rate this patient's current degree of psychiatric impairment?

☐ I do not have sufficient information to make a reasonable assessment.
☐ Essentially good functioning in all areas. Occupationally and socially effective.
☐ Moderate impairment in occupational functioning. Limited in performing some, but not all, occupational duties. Able to maintain meaningful interpersonal relationships.
☒ Major impairment in several areas, e.g., work, family relations. Avoidant behaviors, neglects family, unable to work.

Do you believe this patient is competent to endorse checks and direct the use of the proceeds? ☒ Yes ☐ No
If no, as of: ____/____/____

Do you believe this patient is competent to execute a Power of Attorney? ☒ Yes ☐ No If no, as of: ____/____/____

Have you completed disability claim forms on behalf of this patient for other insurance carriers? ☐ Yes ☒ No
If yes, please provide the name of the company(ies):

Are you related to this patient by blood or marriage, or are you a member of this patient's household? ☐ Yes ☒ No

Are you this patient's business partner, professional partner, employer, or a person who has a financial affiliation or business interest with this patient? ☐ Yes ☒ No

Our goal is to understand the extent to which your patient is restricted or limited by the chief complaints outlined above. If we have additional questions after reviewing this form, a claim professional or clinical consultant may contact you.

What is a convenient day and time for us to call? M-F 9am-5pm

What telephone number would you like us to use? (404)987-8695

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties or denial of insurance benefits.

Physician Signature: Aleeza Parkey, LCSW	Date: 04/25/2023
Physician Name (please print): Aleeza Parkey, LCSW	Medical Specialty(ies): Licensed Mental Health Provider
Office Telephone No.: (404) 987-8695	Office Fax No.
Office Address, City or Town, State or Province, Zip Code: P. O. Box 917 Locust Grove, GA 30248	